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CHAPTER 5.0 STAKEHOLDER PERCEPTIONS OF APPROPRIATE NURSING HOME MINIMUM STAFFING: REPORT ON FOCUS GROUPS WITH NURSE AIDES[1]

5.1 Background, Objectives, and Brief Overview of Results

In an effort to discuss staffing issues with direct care workers and nursing facility management, HCFA funded a series of activities to obtain information and input directly from different types of stakeholders in long term care. The information obtained through these activities was intended to be utilized in conjunction with the quantitative analysis of staffing and outcomes and to help interpret the results of those analysis.

To this end, a series of eight focus groups were conducted among Nurse Aides (NAs) currently working in long term care facilities to discuss staffing in their nursing facilities. The main topics discussed included how staffing schedules are determined and the extent to which NAs have input into those schedules, their facility's processes for handling sick calls and dealing with absenteeism, the effects of staffing shortages on residents and on direct care workers, and ways in which facility management might be able to reduce absenteeism. Additional topics included changes in resident's acuity, the relationship between NAs and licensed nursing staff (e.g., RNS, LPNs), and the processes and staffing for meal times. Two focus groups each were conducted in Washington, DC; Baltimore, Maryland; Boston, Massachusetts; and Philadelphia, Pennsylvania. A total of 74 NAs participated in the groups, representing 33 different long term care (LTC) facilities.

In addition, telephone interviews were conducted with nursing facility staff to examine the mechanics of

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staffing in nursing facilities. The objectives of these interviews was to learn how schedules are made, who does the scheduling of licensed and unlicenced staff, whether direct care staff have any input into the schedules, and what happens when staff call in sick or don't show up for an assigned shift (i.e., how those empty slots are filled to ensure adequate staffing throughout the facility). The investigators were specifically interested in examining the issue of absenteeism among NAs, including how pervasive it is in facilities and what efforts the facility management employs to reduce it. The interviews also contained questions about the adequacy of current staffing levels, ideal staffing ratios, and recruitment and retention of staff. In the majority of cases, the Director of Nursing (DON) was interviewed. In several facilities, however, the Administrator completed the interview, usually with DON input. A total of 11 interviews were completed.

Results of the focus groups show that scheduling is generally conducted by the facility DON or a staffing scheduler, and NAs have very little input into the schedules, other than to request leave. NAs are hired for a particular shift, many have permanent assignments, and most like the stability of permanent assignments. Most NAs reported that absenteeism, either in the form of calling out sick or not showing up to work a scheduled shift, is a pervasive problem that leads to staffing shortages. Reasons for absenteeism varied; however, reasons centered mostly on NAs being overburdened and burned out, in addition to being underappreciated by other facility staff. Processes for handling staff shortages caused by staff calling out sick (or no call/no shows) varied also. Practices to fill the vacant slot include tapping into existing facility staff, either through staff who are off duty or by asking for overtime, is the first, and often preferred option to fill the vacant slot. Per diem or agency staff were usually the second and third choice to fill the vacant slot. When asked about ways to reduce absenteeism, the NAs suggested employee appreciation programs, being treated with respect by other facility staff, monetary incentives, proper staffing (staffing to an adequate level) and scheduling incentives (more choice of days off, assignments, etc.).

The workload of the NA participants varied by facility and by shift, but on average, the staff ratio on the 7:00 AM to 3:00 PM shift was between 1:8 and 1:10 NAs to residents. The NAs also reported working short fairly frequently, up to about 80% of the time in some facilities. When asked about the consequences of short staffing, the NAs reported resident's quality of care is impacted in such ways as bed sores, incontinence, and decreased range of motion. NAs also reported staff shortages impacted residents in quality of life areas such as not being able to spend time talking to residents or being able to provide basic grooming assistance. Participants also reported an increase in NA injuries as a result of staffing shortages. When working under-staffed, focus group participants reported that showers are often not provided, meal times are hurried resulting in some residents going without food, and NAs do not have enough time to get residents water when they need it. This is a concern since dehydration is a problem among nursing home residents. Many participants noted that resident acuity has been increasing over the last three to five years, but that staffing levels have stayed the same or even decreased, making their workload even heavier.

The NAs participating in the focus groups were asked about the relationship between the NAs and the licensed staff (e.g., RNS and LPNs). While some NAs reported having good working relationships with the licenced staff, many felt that the RNS, LPNs, and NAs did not function as a team, and in fact, the relationships were often reported as tenuous and counterproductive.

One of the goals of the focus groups was to try to determine whether NAs have adequate time and support to conduct some basic, daily routines, such as feeding, ambulating or toileting residents. However, due to the two hour time limit on the focus group, this discussion centered on feeding and meal times only, and did not include discussion of other daily activities. Overwhelmingly, focus group participants noted that the time allocated for meals was generally inadequate to meet the needs of the residents, particularly those residents who need assistance with feeding. Most NA participants did not have a set amount of time to assist residents with meals, but noted that if too much time was spent assisting residents during meal times, the remainder of the day's workload would be negatively impacted. Few NAs reported that their facilities utilized other staff, such as meal aides or volunteers, to help residents at meal times.

The concluding topic for the focus group discussions centered on describing the most positive and most negative aspects of being a NA. Overwhelmingly, most participants noted they are in the field because of the residents, and felt that the strong bond between residents and NAs is a very positive aspect of their job, even in the face of staffing shortages and being overworked.

Results of the facility staff interviews show that in most cases, the DON is responsible for scheduling facility staff, and typically spends about 50% of his/her time working on staffing-related issues. Absenteeism (i.e., sick calls, or no call-no shows) is problematic, and frequently results in staff "working short." Recruitment and retention, particularly of nurse aides, is the biggest staffing-related problem for most of the interview participants. As a result, many interviewees noted that their current staffing level is lower than their ideal level. Many participants also noted that the current (short) staffing situation in facilities is due to low unemployment rates and a shortage of available labor.

Most of the facility staff interviewed reported that their facilities routinely staffed above the State minimum staffing standards that were typically viewed as inadequate. The large majority of interviewees reported that their own staffing levels are adequate, although some noted that this would not be true if their census was higher.

The labor shortage was mentioned repeatedly as a major barrier to maintaining high staffing levels. Not only is it difficult for facilities to find adequate numbers of employees in an economy of low unemployment, but not being able to hire a full staff means that existing staff work "short-handed" much of the time, which in turn leads to high absenteeism and low retention rates. Another problem facility staff noted is a poor work ethic among employees, especially younger employees and those in welfare-to-work programs. One of the most common complaints among the interviewees was that staff morale

is low, which may be a problem that some facilities are interpreting as a poor work ethic. Several interviewees noted that they try to include nursing staff when making scheduling decisions, allowing for preferences in terms of which days to work or which residents to care for. Yet even in facilities with a pleasant work environment where staff have a voice in scheduling, there is still difficulty in hiring and retaining nursing staff because of low wages, low unemployment, and competition from less physically demanding and less stressful job possibilities.

5.2 Methodologies for the Nurse Aide Focus Groups and the Facility Staff Interviews

5.2.1 Focus Group Methodology

A moderator's guide was drafted and pilot tested during two focus groups conducted at the annual meeting of the National Citizen's Coalition for Nursing Home Reform (NCCNHR) in November 1999. These two initial focus groups included a total of 22 Nurse Aides from around the country, representing LTC facilities in eight different states. After some revisions as a result of these focus groups, the guide was disseminated for review and comment to representatives from the Alzheimer's Association of South Carolina, the Service Employees International Union (SEIU), the Paraprofessional Healthcare Institute, the American Federation of State, County, and Municipal Employees (AFSCME), and the Career Nurse Assistants' Program. Comments from these groups were incorporated into the final version of the moderator's guide, which can be found in Appendix D.

Since funding was not available for use of a professional recruiting firm to secure focus group participants, Abt staff were responsible for recruiting NAs for the groups. To this end, the investigators sought input and recommendations from various stakeholders for either NAs to participate directly in the groups or individual nursing facilities whose staff (usually Administrators or DONs) might be willing to help recruit participants and coordinate the groups.

In the end, in addition to the two groups conducted at the NCCNHR meeting, two groups were conducted in the Baltimore, Maryland area, with representation from five different LTC facilities, two groups were conducted in the Boston, Massachusetts area, with representation from six LTC facilities, one group was held in a facility in Lansdale, Pennsylvania, and the final group was conducted at a training and education center in center city Philadelphia, and included NAs representing six area facilities. Table 5.1 shows the location of the eight focus groups and the composition of each group, including the number of NAs per group, the years of NA experience per participant, and the shift currently being worked by each focus group participant.

Table 5.1 Composition of Focus Groups		
Focus Group Location	**Participant Experience as a Nurse Aide**	**Participant Shift**
Washington, DC #1 11 participants representing 7 facilities	8 years 11 years 9 years 12 years 5 years 20 years 1 year, 3 months 10 years 16 years 19 years 31 years	3-11, 11-7 7-3, 3-11, 11-7 7-3 7-3 7-3 11-7 7-3 7-3 3-11 4-12 7-3
Washington, DC #2 13 participants representing 8 facilities	15 years 2 years 14 years 8 years 6.5 years 26 years 3 years Leaving the profession 21 years 23 years 11 years 12 years 15 years	7-3 3-11 7-3 7-3 7-3 7-3 3-11 7-3 11-7 11-7 7-3 7-3 11-7
Baltimore #1 7 participants representing 3 facilities	3 years 20 years 5 years 5 years 2.5 years 2.5 years 34 years	7-11 3-11 7-3 3-11 7-3 7-3 and 3-11 7-3 and 8-5
Baltimore #2 10 participants representing 2 facilities	1.5 years 12 years 15 years 6 years 14 years 16 years 11 years 11 years 2 years 1 year	3-11 and 11-7 3-11 and 11-7 7-3 7-3 7-3 7-3 7-3 and 3-11 7-3 and 3-11 7-3 7-3

Table 5.1 Composition of Focus Groups		
Focus Group Location	**Participant Experience as a Nurse Aide**	**Participant Shift**
Boston #1 9 participants representing 3 facilities	20 years 5 years 7.5 years 4.5 years 5 years 7 years 4 years 6 months 6 years	7-3 7-3 7-3 and 3-11 3-11 and 7-3 3-11 11-7 7-3 7-3 and 3-11 3-11
Boston #2 5 participants representing 3 facilities	19 years 5 years 7 years 19 years 8 months	6-2:30 7-3 7-3 6-2:30 7-3
Philadelphia #1 9 participants representing 1 facility	1.5 years 3 years at current facility 9 years 4 years 9 years 5 years 3 years 4 years 7 months	7-3 7-3 7-3 7-3 7-3 7-3 7-3 7-3 7-3
Philadelphia #2 10 participants representing 6 facilities	8 months 10 years 6 years 6 years 12 years 8 years 15 years 10 years 12 years 13 years	7-3 7-3 8-4 11-7 6:30-2:30 7-3:30 7-3 7-3 11-7 7-3

5.2.2 Methodology for the Facility Staff Interviews

The facility staff interview guide was developed by Abt Associates' staff with experience in long term care; a former DON with many recent years experience as an RN in long term care facilities lead the design of the interview guide. In addition, the draft interview guide was reviewed by staff at Survey Solutions, Inc., who also have extensive long term care and DON experience. The final version of the

interview guide can be found in Appendix D.

Because the scope of this activity was limited to approximately ten interviews, the investigators did not randomly select facilities and staff to participate. Instead, the investigators sought recommendations for potential participants from colleagues at the National Citizens' Coalition for Nursing Home Reform, the American Health Care Association, the Service Employees International Union, and Survey Solutions, Inc. The investigators asked for facilities and staff that would be likely to participate in a 30-45 minute telephone interview, and the investigators requested a range of facilities by size, location, ownership, and profit-status. The investigators also asked for facilities with a range of staffing levels, rather than targeting just well or poorly staffed facilities.

The investigators obtained recommendations for 20 facilities to be included in this activity. The investigators then contacted the Administrator and/or DON at each facility to determine their willingness to participate in the interviews, and to schedule an interview date and time. Eleven interviews were conducted. Table 5.2 shows the characteristics of the facilities included in the interviews.

Table 5.2 Characteristics of Facilities Included in the Interviews

Facility	Location	Urban/Rural	Size (beds)	Profit Status	Chain/Indep
1	Florida	Urban	179	For-profit	Chain
2	Wisconsin	Suburban	122	For-profit	Chain
3	Maryland	Suburban	162	For-profit	Chain
4	Connecticut	Suburban	90	For-profit	Chain
5	Maryland	Urban	150	For-profit	Chain
6	Ohio	Rural	150	For-profit	Chain
7	Washington	Urban	215	Non-profit	Chain
8	Pennsylvania	Suburban	181	For-profit	Independent
9	Louisiana	Urban	202	Non-profit	Government
10	Ohio	Urban	101	For-profit	Independent
11	Louisiana	Urban	119	Non-profit	Independent

5.3 Detailed Focus Group Findings

The following sections present the major findings from the eight focus group discussions. While the

moderator's guide (in Appendix D) divided the focus group discussion into specific topic areas, many of the actual discussions did not following the guide topic-by-topic. Instead, because of the inter-related nature of the topics, many of the discussions moved from one topic to another and back again as navigated by the respondents and necessitated by the nature of the discussions, rather than as commanded by the moderator's guide. As such, the discussion findings are presented in the manner in which they were reported in most of the focus groups, rather than in the manner they were organized in the moderator's guide. The general categories of findings include: 1) staffing schedule determinations; 2) sick calls and absenteeism; 3) workload and outcomes of short staffing; 4) relationships between NAs and licensed staff; 5) processes for meal times; and 6) positive and negative aspects of being a NA.

5.3.1 Staffing Schedule Determinations

Focus group participants were asked to describe the process of developing staffing schedules in their facilities and to comment on the adequacy of those processes. Participants noted that much of the scheduling in their facilities was conducted by a staffing coordinator or scheduler who generally worked full time in this capacity. In some facilities, development of the staffing schedules was done by the Director of Nursing (DON), while in other facilities, the scheduler was a clerical person who worked in the administrative offices of the facility. Most schedules were developed on a two-week basis, although some facilities developed their schedules monthly.

NAs reported selecting the shift they would work (i.e., usually 7:00 AM. to 3:00 PM, 3:00 PM to 11:00 PM, or 11:00 PM to 7:00 AM) at the time of hire, and reported very little additional input into the schedule, other than to request leave or vacation. There was some flexibility in assignments to a particular unit or floor, although most NAs reported (and desired) fairly permanent assignments. The exception being when a unit/floor was under-staffed and NAs would have to be shifted around to cover the under-staffed unit/floor. Some participants noted that they worked the same days each week, while others reported working variable days. For those who work variable days each week, many do not know which days they are assigned to work until the schedule is complete and is disseminated to the NAs.

> "It's usually pretty flexible if you have to leave. My dad has been very sick. If I get a call, I call my supervisor and let her know. They're usually pretty good about that."

> "We can float on any different floor any given day. If you come in the morning and some other floor is short, they will float you to another floor."

> "You make up a schedule when you first come in. You choose the shift you want to work. After that you have no input into the schedule. They schedule the work. You don't have set days off. They try to work with you last minute to give you set days off,

but you can be off Tuesday of one week and work Tuesday the next week."

A few NAs reported that their facilities give them the freedom to work out the schedule among themselves, by posting a blank schedule in the nurses station and allowing staff to fill in the days they want to work. Priority is given to full time staff, starting with highest seniority, with lower seniority and part-time staff to fill in the vacant slots. This model, however, was only found in a few facilities; most facilities do not afford very much freedom to NAs in developing staffing schedules.

In general, NAs reported very little input into the scheduling process, although most did not view this as too problematic. The schedulers were generally amenable to making changes (if possible) to the schedules. In many facilities, NAs could either request that the staffing coordinator make a needed change in the schedule or could coordinate a change among themselves as long as the slot was filled.

> "If a CNA [Certified Nursing Assistant] wants time off, we have a sheet you must fill out two weeks before the schedule comes out and the coordinator will work it out. If not, you have to find someone to work for you."

5.3.2 Absenteeism

The focus groups included a thorough discussion of absenteeism, including staff who call out sick and no call/no shows. Participants were also asked about the reasons for absenteeism, facility processes for handling sick calls and other staff vacancies, and ways that facility management might be able to reduce absenteeism. Later topics in the focus groups explored the extent of absenteeism in facilities and the consequences of absenteeism on residents and on direct care staff.

5.3.2.1 Reasons for Absenteeism

The main reasons behind the absenteeism cited by the NAs are that the aides are tired, frustrated, aggravated, and burned out. Many participants noted that they are overworked on a daily basis, which leads to call outs because they need time to rest.

> "I work all day taking care of 12 or 13 people, running around, with maybe 15 minutes for lunch ... how much will the body let you do? I can't take it."

> "It's stressful. If you work with five CNAs, four of them are going to have eight people and the fifth person is going to have nine. Some people just get pissed off, especially on a day where you have five people (CNAs) and you know you're going to have five people because you did the schedule. Some of them might say they're not coming tomorrow because they did enough work for two days. They don't look at it like, 'I'm hurting my coworkers,' they look at it like, 'I'm doing something to the supervisor.'

But she could care less."

"People are burned out. If you work short for five days, you're not going to go in because you're tired. It becomes a rotation. It's not that you don't want to come to work. Your body is tired."

Some NAs said they called out sick because they felt their hard work was unappreciated, and that they weren't treated with respect by their supervisors and colleagues. The aides who had to work when others called in sick were particularly frustrated because their extra work on short days was not recognized.

"Absenteeism causes an absence of feeling that the nursing staff care about what's happening. We work short and no one appreciates it. I get work done through other aides. Somehow you need to make them appreciated. I take time off just to relieve stress for me. I'll stay home one day just to recharge. It's not the aides being irresponsible. Management needs to create an environment to make people want to come. Nurses should care what happens to aides and patients."

"You couldn't go any faster if you wanted to. You're behind already when you get on. And you're underappreciated. Instead of saying thanks for what we did today, they say why isn't this done?"

In addition to their work being unappreciated by others, some NAs expressed difficulty feeling good about their work, particularly when they work short staffed and struggle to get everything done.

"I am working so hard to do what I am doing. You want to leave and feel a sense of completion, that you're doing a job good and can feel good about it. You don't, though."

"How can anyone give quality care under this kind of stress? It's impossible under these circumstances."

Often NAs attributed call outs to co-workers being lazy or trying to get back at their supervising nurses. But other participants argued that it is the co-workers who bear the brunt of the call outs, not the nurses. Many NAs said that they would come in on their days off just to help their co-workers who would be working short that day.

"A lot of it is knowing who your coworkers are. They should take the time to see who they're hiring because some people are lazy so we have to do all the work. They don't understand the team concept."

"I look at the schedule to see who I'm working with and I dread it."

"I had to come in sick because there was no one to come in and they would've had to work with only 2 people (CNAs)."

5.3.2.2 Processes for Handling Shortages Due to Staff Calling Out Sick

Facility procedures for handling sick-calls varied, but usually required that NAs call one to four hours in advance to give the facility time to replace the staff. Some participants said their facilities called aides at home, used part-time staff, or agency staff as replacements. Other participants said their facilities offered monetary incentives to entice staff to cover sick calls. Most of the NAs noted that they generally worked short when other aides called in sick.

"They try to call staff that are off, or the part-timers to give them extra hours. I think they try to work with the part-timers first because they don't have the week full already. Then if they can't get the part-timer, they'll go for the full-timer who had the day off. I think on occasion they have called the agency when they can't get anybody. Sometimes even the agency can't help us and we have no choice, we work short."

"It depends on how much time they have to call anybody. A lot of people object to being called in the middle of the night."

"We have bonuses on top of overtime to bring in extra help. Especially on weekends. $20 an hour bonus."

"We have a policy that they have to call everyone before they can require overtime. Have to have union and management agree that it's an emergency. Usually we are just short."

A few NAs said their facilities had systems in place to prepare for call-outs, such as a list of aides who want to be called on short notice or an aide designated to stay if someone doesn't come in.

"They ask you to put your name in to be called to come in for an emergency any time during the night. If you don't want that, they won't bother you. They'll say I know you're off today, but can you come in?"

"We have a star system. If someone doesn't come in and we don't have another area to pull from, the star person has to stay. You know in advance you might have to stay. Extenuating circumstances are different. We check to see who might want to stay to get overtime."

Many NAs said their facilities would pull Aides from other floors to compensate, thereby leaving the other floors short staffed as well. Some aides commented that there are often times when the facility can not find a replacement, in which case the aides are forced to work short staffed. Other aides noted that facility management rarely even tries to replace sick calls.

> "They try to replace when they call in sick. If they can't, you just have to manage. Lately, and it's a big difference from when I first started, they try to find help and if they can't then you just do what you can."

> "If they don't have anyone from another floor you have to work as is."

> "In my facility, they don't even try to substitute."

> "If no one stays from a prior shift you're stuck."

> "They ask us to call in two hours before the start of the shift, but we don't get coverage so what does it matter?"

5.3.2.3 Ways to Reduce Absenteeism

The NAs had various suggestions for reducing absenteeism in their facilities. Many of the ideas centered on recognition for their work and respect from their supervisors and colleagues.

> "Put your foot forward trying to communicate. It makes people want to work. Treat people with respect."

> "They talk to us like we're little kids. We're all adults. Talk to us on an adult level and we can accomplish a lot."

> "They should encourage us. Something as simple as a thank you."

> "Instead of making incentives to get people to work, there should be recognition for being there."

A few NAs mentioned specific recognition programs, such as employee of the month, as a way to acknowledge their hard work. Other aides commented that their facilities have employee appreciation programs but they are rarely utilized properly.

> "They should have employee appreciation once a month."

> "I've been on the Employee Recognition Team for about four years now. Since we've started the team we haven't recognized one employee. Instead we plan parties and trips."

Monetary incentives were mentioned as a way to reduce absenteeism, such as bonuses for perfect attendance.

> "For perfect attendance, there is a $50 bonus, if you show up on time and don't call out."

> "If you work three months without a call out, you get $100. If the whole unit does it, you get $125 each."

Several participants suggested that proper staffing and scheduling would help reduce absenteeism because the NAs would work short staffed less often. Suggestions included bringing in extra staff for the busiest times of day, scheduling an extra aide in anticipation of call outs, and ensuring that the schedules are accurate and the staffing levels sufficient.

> "If they added an extra aide to anticipate call-ins, it would help."

> "There should be someone to come in from the busiest time of 5-9 to help us feed and put to bed."

> "Sometimes they schedule you even if you're taking vacation or not an employee anymore just to make the schedule look full."

> "Sometimes the same CNA is on (the schedule) more than once."

> "Sometimes I think I could do the staffing better than [my supervisor]. She makes a schedule and she schedules four people for a Saturday [when there should be five scheduled]. She knows not to wait until Saturday to try to find help. If you only schedule four people, it's not fair."

> "The least they should do is schedule six people for every day. If somebody calls in it's no problem because six people are scheduled. If we have only five people scheduled, what do you expect [when someone calls out sick]?"

> "Besides call outs, we need staff. We need enough people scheduled."

> "We don't even have a full staff before call outs. We don't have enough people to

work."

"When we're fully staffed, we're short staffed."

5.3.3 Workload and the Outcomes of Short Staffing

Following the discussion of absenteeism, the dialogue moved to the topic of workload, both standard (or anticipated) workload (i.e., when the facility is fully staffed and all staff report to work), and typical workload which in many cases was different from the anticipated workload. The moderator asked the participants to state how many residents staff would be expected to care for if their unit/floor was fully staffed, how often they work short because of sick calls or absenteeism, and the effects of under-staffing on residents and direct care staff.

5.3.3.1 Typical Workload

The focus group moderator asked participants to identify what shift they normally worked (typically either 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, or 11:00 PM to 7:00 AM, although there was some variation to those standard shifts) and how many residents they would typically have to care for if their unit/floor was fully staffed and everyone reported to work as scheduled. This exercise was conducted in order to obtain an understanding of the usual workload of NAs and to provide a frame of reference for the discussion on the extent of short staffing in facilities.

As noted in Appendix D, the majority of focus group participants worked the 7:00 AM to 3:00 PM shift, although there was representation from both the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts. For those who worked the 7:00 AM to 3:00 PM shift, 28% of respondents stated that their typical workload was 1:7 NAs to residents. Slightly more than 48% of respondents stated that their typical workload ranged from between 1:8 to 1:10 NAs to residents, and 24% of respondents stated their typical workload was 1:10 NAs to residents. The responses ranged from as high as 1:5 NAs to residents to as low as 1:13 NAs to residents.

While there were fewer focus group participants who worked the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts, the average across respondents for those shifts was 1:11 NAs to residents on the 3:00 PM to 11:00 PM shift and 1:18 NAs to residents on the 11:00 PM to 7:00 AM shift.[2]

[2] In the aggregate, the typical workload as reported by the NAs in this study is typical of that found throughout the United States. If the investigators assume that the NAs average ratio across the three shifts was about 1:9, 1:11, and 1:18, the average across the three shifts is 1:12.7. This 12.7 is equivalent to 4.72 NA minutes per hour or 113.38 minutes per day or 1.89 hours per resident day - very close to the median time reported across the U.S. Forty-seven percent of nursing homes report 1.9 NA hours or less per resident day. See Chapter 3, Appendix B.4.

5.3.3.2 How Often Staff Work Short-Handed

Once the typical workload was established, the moderator turned the discussion to the extent of short staffing in facilities, by asking participants how often they work understaffed. Responses ranged from "sometimes" to "almost always," although across all eight focus groups, most respondents reported working short staffed at least occasionally, with the majority reporting that they worked short staffed constantly. Many participants talked about being asked to work overtime or come in on their day off to fill a vacant slot on a particular shift/unit, only to find out that the shift/unit was still short staffed even with their additional assistance. Some participants even noted that they volunteered to be called for overtime, but that they rarely were called when the facility was short staffed.

> "We work short most of the time when a staff member calls in sick."
>
> "We are short every day and weekends are the worst. People are sick or they don't schedule enough people. Sometimes the same CNA is on twice. Sometimes they schedule you even if you're taking vacation or you're not an employee anymore just to make the schedule look full."
>
> "Today is Tuesday. I worked short Sunday and Monday. Usually I work short once a week."
>
> "We have a lot of work and we're always working short. The assignments are heavy."
>
> "It's easier to count how many times we're fully staffed."
>
> "I'd say we're short 80% of the time."
>
> "At my facility, we're short 30% to 40% of the time. There's a new Administration and DON so it just started happening. It used to be 100% full."
>
> "We work short almost every day. Weekends are really bad. We had new people trained but they didn't show up to work. Sometimes they have to book us short because there are not enough people. It's not fair to make people come in on their days off. People are getting burned out."
>
> "We are still responsible for everything. There was one day I was working ... they asked me to do the 11:00 PM shift because they were short. I made the fourth person. I hate when they do that because I hate to say I'll work overtime when they're still short even with my help. And they don't usually say it until after I already commit to it."

"Many times I offered to come in if short, but no one calls, even though they are short."

5.3.3.3 Affects of Short Staffing on Residents and Direct Care Workers

Focus group participants were asked to describe the effects of short staffing not only on residents, but on direct care staff as well. Most frequently, participants mentioned injuries as the biggest impact of short staffing on NAs, followed by a lack of satisfaction and sense of accomplishment with their jobs. NAs noted that they wanted to feel good about their work, but when they couldn't work to the best of their ability, the sense of failure had a big impact on their emotional outlook. Participants very easily identified quality of care and quality of life outcomes effected residents as a result of short staffing, including pressure sores, incontinence, and diminished emotional well being.

"Staff gets injuries due to overload or work. Back injuries. The ratio is going up of those on compensation and disability."

"Quality of care suffers because care is lacking. You get more skin breakdowns."

"Emotionally it takes a toll. They feel bad because they think I don't want to spend time with them. They get mad at me for not brushing their hair or doing their lipstick. It's not that I don't love them or care, but I don't have time."

"People can tell by your face and attitude when we're short. It's getting them as mad as we are. It's not our fault and it's not their's."

"Having conversations with alert residents suffers. When we have time, I love to talk to the residents."

5.3.3.4 What is Done Differently when Working Short-Handed

Focus group participants were also asked about the types of activities that might not get done when staff is short handed, and the workload is high. Overwhelmingly, NAs noted that showering and basic grooming were usually the first activities to be skipped when staff were short on time. Vital activities, such as eating/meal times and passing water are also impacted by short staffing.

"Don't just say you want a job done, give me the tools to do it. I can give 100% care to 6 patients in 72 hours. You up that, then I do the best I can, and that's all I can give."

"Showers are the first thing to go. Eating is also affected. Food is put in front of sleeping residents and taken away before it's eaten. Residents are also left in urine and

feces for a long period of time. Range of motion is not done."

"One of the first things to go is showers. Two times a week they're supposed to get showers. Might get one once a month."

"They might get their face washed. If it looks clean, they might not."

"First thing that goes when we're short is the bath. We have two people to give showers. If we're short, the showers go first. After showers goes food."

"Baths, ice water don't get given out. If we have constant ringers, a whole lot doesn't get done."

5.3.3.5 Changes in Resident Acuity and Staffing

Following the discussions on workload and short staffing, the focus groups naturally progressed to a discussion of acuity and how this relates to current staffing. Most of the NAs agreed that resident acuity has gotten higher over the years while the staffing ratios have remained the same or have decreased. Some nurse aides attributed the lack of adequate staffing relative to acuity to financial issues. In addition, several participants felt that NAs are not properly trained to adequately care for higher acuity residents.

"Residents need more care now. Nursing homes are receiving money for that care but are not giving staff money to take care of them. Two CNAs should be doing some patients in order to give proper care. Nurses used to be at your side turning, but not anymore. We're not trained for tubes and ventilators but we're working with them. Sometimes we need two CNAs but don't have the staff."

"Ten years ago, little old ladies would come in with their suitcase and talk to you. Now they come in on a stretcher and are really sick."

"We're getting a lot sicker patients who require more care. Tracheotomies, hand holding, therapeutic touch needed. Not change really in staffing though."

"There's a mixture of people – drug addicts, homeless, sick elderly. We can't care for them. It's one extreme to the other. We're not qualified for it."

"The biggest is the state code of residents per aide – it was set 25-30 years ago when we didn't have the same acuity. Mostly psych in my facility, very violent with g-tubes [gastrostomy feeding tube] and IVs, too. We play referee all day, and are short most days. 1:10 is perfect for them, but mostly we're 1:15. They don't see that acuity has

changed. We can't do it anymore in that time. We need more time."

"At our place, we used to call the fourth floor the penthouse. Those people could walk. Most of them were just either supervised or they needed minimal assists. Now on the fourth floor, they have lifts and they have people who need to be fed. It used to be like assisted living. Now you can see they're getting in people who are sicker and need more and more care. They really are much sicker residents coming in."

5.3.3.6 Unique Staffing Practices to Stretch Existing Staff

The final topic in the section on workload and short staffing centered on unique staffing practices to help "stretch" existing NA staff. While some facilities had implemented practices to aid overburdened staff, these practices were not widely reported by the focus group participants. Ways to stretch staff included use of meal aides, bed makers, and shower aides, although very few facilities represented by the focus group participants had instituted these practices. In addition, a few participants mentioned the use of volunteers to help with meal times and activities, for example, although this practice was not widely pervasive. Finally, some NAs mentioned that RNS and LPNs sometimes help with meals when the NA staff are working short staffed, although again, this practice was not pervasive throughout the groups.

5.3.4 Relationships Between Licensed and Non-Licensed Staff

The focus group participants spent a fair amount of time discussing the relationship between the licensed (e.g., RNS and LPNs) and non-licensed staff, since much of the NA's job relies on interacting with licensed staff and functioning in a team environment. Particular issues discussed included how NAs interact with the RNS and LPNs, and whether and how licensed staff help NAs when they are short staffed. It was noted by NAs that a short staffing situation could be made better or worse depending on the relationship between the NAs and the licensed staff. However, more often than not, NAs complained of poor relationships with licensed staff.

The relationship between the nurses and the nurse aides varied considerably depending on the people involved. Many of the NAs felt they weren't respected by the nurses they work with, and others thought the nurses did not contribute enough to their overwhelming workload. Yet other nurse aides thought the nurses they work with were very helpful and understanding.

"We really need an exchange of respect, teamwork, understanding. We need to understand her [the nurse's] tasks too."

"The nurses are so overwhelmed with their own work that they can't help."

"You get those nurses that won't do anything, but others will do anything for you."

"We have a wonderful charge nurse at night. She's there if we need her. I'll help her when she's backed up too. That's how we get along."

"They help us turn residents, even change the diapers."

"We're pretty lucky up at my place in regards to the nurses, because we have some nurses help us. If somebody is ringing for the bathroom or a bedpan, they'll put them on the bedpan and tell us so we know to listen for them ringing again soon."

"In most cases, LPNs are fine. RNS are different. LPNs do meds, treatments. RNS run the floor. They are supposed to be much smarter."

"Nurses don't have time to help. Many say, I already did my time, I don't do that."

"A nurse would rather find me to put someone on the bedpan instead of just doing it themselves."

"We have a lot of new ones out of school. They go by the book instead of hands on. They think they're better than us. They only want to push meds and jump on the phone."

"It's like a class system. No real interaction between the types of nurses. Only when something goes wrong do they all come together. I never see the nurse."

"We had three nurses and two CNAs one night. The nurses won't help us, though."

"We're older than some of the nurses yet they talk to us like we're beneath them. It's about respect. They need to give respect."

"The nurses don't help. They're there to assist us and they don't ever assist us. They can be there and if a resident says I want a glass of water or I want the bedpan, they're going to find you. Which is taking more time than if they would have gotten it themselves."

"They call me to give a glass of water. They have water right there on the nurses' cart. If someone is asking for water, they'll look to see which CNA has that person and go find the CNA to tell them so and so wants water. You're looking at them to see if they have two hands or what. You have water right there on your cart. Give them some

water."

"Like today for instance. I was giving my showers and one of my residents made a mess in her room. And the nurse called me from my shower to tell me she made a mess in her room. Clean it up, I said, and I closed the shower door. Because they can do it too. They're going to let somebody stay in that mess? I'm already in the shower. I'm not going to drag them out of there. Safety comes first. You can't leave somebody in the shower to go take care of somebody else. It's one at a time."

"Sometimes you can say to a nurse, I see a red pressure area on somebody's heel. She might just say 'okay.' Then two weeks later, it's open and they're saying why didn't someone report this to the nurse? They blame everything on CNAs."

"We were short. They had an admission coming in. I don't see why the nurse can't weigh that admission, take vital signs on that admission, see how tall they are. I had ten people already and a new admission comes in. I had to take care of the new admission. And with the new admission, because of their age and condition, they're agitated. They're fighting you and you don't have time to go take care of the other ten people you have. The nurse tells you all the things she needs so she can leave by 11:00 PM, and says I'm not going to get in trouble so you'd better do this. You're like my god, which way can I go? You have to get it done or the nurse can write you up for it. It can make you quit if you're short. They're really trying to get better. I see them trying to hire more staff. The nurses need to help when our staff is short. I know they have their papers to write and stuff but me too, two hours out of the morning time they're sitting there talking to each other. From 12:00 PM to 1:00 PM they pass meds and from 1:00 PM to 3:00 PM they don't do anything but sit there and talk to each other. They should help when we're short. We had a nurse manager who would roll up her sleeves and help. They should pitch in. There's no way someone should take care of ten people, especially on the 7:00 AM to 3:00 PM shift. You have to get people up, washed, dressed. With ten trays to pass."

5.3.5 Time it Takes to Feed Residents

Focus group participants were asked to discuss the meal time processes in their facilities. Specific questions centered on the typical workload during meals (i.e., how many residents needed some assistance with feeding, how many required total assistance with feeding, etc.), how much time they have to feed residents and whether that time is adequate, and facility practices to aid meal times.

5.3.5.1 Workload at Meal Times

The meal time workload varied considerably across the facilities represented by the focus group participants. Almost all focus group participants had some residents who required total assistance with feeding, some who required minimal assistance with feeding, and others who were totally independent in feeding.

5.3.5.2 Time Allowed for Meals

What did vary less, however, was the time NAs were allocated to feed the residents on their unit/assignment. Some NAs noted that they have as much time as they need to feed residents, while other NAs noted that they only have a specified time period within which to feed all their residents, regardless of the resident's ability to feed themselves or even participate minimally in their feeding. However, many of the NAs who had as much time as they needed to feed residents commented that taking too much time to feed residents would impact their schedule for the remainder of their shift. Outcomes of hurried meal times were frequently included in the discussions about the time allowed for feeding.

> "We have 45 minutes for lunch, with 13 total feeds and three assists out of 30 residents. While we're passing trays to some residents, we have other residents digging through trays. Two residents are on liquid diets, which takes ten seconds each. Pretty easy. A couple are slow feeds. They forget to swallow. It takes a long time to feed these residents, but we don't have a long time. I save the longest feeds for last, and often they don't finish their meal. That's where dehydration and malnutrition come in."

> "Our new supervisor wants everyone in the dining room to eat. We get 45 minutes. We have to take the tray away almost as soon as we give it to them. There's no chance to eat. Residents complain about it. The CNAs have 12 residents on a 7 ½ hour shift. If we give a resident 10 minutes of time, we are over the limit."

> "We have however long it takes to do it. Sometimes we're still feeding two hours later."

> "It depends on the CNA. Because me, if I know my resident is a feeder and they like to eat, I'll take the time and give them all. But the thing about it is, if you have a resident you have to encourage too much to eat, even though you know they might eat if you encourage them, you're not going to sit there and keep encouraging them. You're going to say, oh well, that's it for today. And you're just going to go. Versus if you know you have the time to stay there and wait with them, you would do it."

> "It takes as long as it takes and sets off the rest of the day. We bring residents to the dining room. Some stay in their rooms for breakfast. But if we have residents who

need help in their room, then we lose someone [a CNA] in the dining room."

"When you're short, you make sure to at least give one bite and one drink. There's not enough time to let them complete the meal, even if they wanted to. You just have to take trays because Dietary is right there to pick them up."

"Some feeders need one-on-one care. It's very time consuming. We have three aides for 31 residents, plus some extras. They feed independently, but we have to prepare everything so they can eat. We have eight feeders and eight for supervision. If you take away an aide for one person, you don't have time to do it."

"There is a lot of weight loss because of not feeding residents. Dehydration. Some residents just don't eat. Some aides take the tray in and don't even try to feed, even if it says 'feeder.' It makes me sick."

5.3.5.3 Processes for Meal Times

The processes facilities employ for meal times were discussed in terms of the locations for meals (e.g., dining rooms versus residents' rooms), the methods for accommodating all types of feeders, and the use of additional staff to help NAs during meal times. There was variation in facility requirements for locations of meals, with some facilities requiring that all able residents eat in dining rooms, while other facilities left it up to the resident to chose to eat in the dining room or the resident's room.

While a few focus group participants discussed the use of round tables with swivel stools to facilitate one NA feeding up to six residents who were dependent in feeding, this practice was not frequently reported among the focus groups. What was more frequently reported was the practice of segregating residents based on their ability to feed themselves. Segregation could be in the form of different areas in the same dining room or through the use of separate dining rooms.

Focus group participants also discussed the use of additional staff to help the NAs with meal times. These additional staff included dedicated meal aides, rehabilitation aides who would assist at meal times, CNAs on light duty due to injury, and to a limited extent, facility volunteers.

"There are 60 residents on the floor. Twenty stay in their rooms to eat. We have seven tube feeders. There are two CNAs for 20 residents in the dining room. Some CNAs set up for six feeders. There is a round table with you in the middle on a swivel stool. This is very common in nursing homes. People look at us like we're cruel people. But this is the way you have to do it in order to get people fed."

"On the third floor we have a feeding list. Some CNAs might have one feeder, or

none, and they still won't help the other CNAs with all the feeders. They'll go around and pass out their trays and then go around and do their work for the rest of the day without helping the ones who have all the feeders. There's no teamwork."

"They are all done on the unit on the evening shift. There's a small dining room. We feed feeders around a table. We sit with them, encourage them to swallow. We get about an hour and a half to pass trays and feed the feeders. We have three meal aides for lunch and breakfast. It's workable. It can be especially workable if the nurse pitches in. We try to feed the same patients everyday so we know what they like."

"We also have volunteers at our place to help us feed. We show them who it is and how to work it. We're lucky that way."

"We can't use volunteers. But people from occupational therapy can help. They can sit there and feed residents because they evaluate them. But if we have housekeeping, rehab, or volunteers around, they cannot feed unless they're certified."

"We have assistants with feeding. Some CNAs on light duty help. Restorative aides also help sometimes."

"The way they do it is not bad. The problem is when there is not enough staff and you have to do more. You physically can't do it. The procedures are okay, the staffing is not."

5.3.6 Most Positive and Negative Aspects of Being a Nurse Aide

The final concluding discussion with the focus group participants centered on the most positive and negative aspects of being a nurse aide, i.e., what's the best and worst part of being a NA? Overwhelmingly, most participants cited the bond between themselves and the residents as the most positive aspect of their jobs and the reason many stayed in the field for so long. Short staffing, being overworked, underappreciated, and the physically demanding nature of the job were the negative aspects most frequently associated with being a nurse aide.

"I know I'm good. The residents make me laugh. I'm not coming just for a paycheck. Someone who does that is not going to stay. It's fun. You need compassion because you're going to get attached."

"The best thing is even though we're short staffed, we can be attached and really care for people. We're part of their families. The hardest thing is being short."

"I care. This is their last place on earth. Why can't we make it more pleasant? The worst part is some of the staff and being short staffed."

"My residents love me and I love them. They could say this resident doesn't know anything, and they might not know if they're coming or going. But if they see you, they smile, and they might know to call out your name."

"The best is the blessing of knowing that I seriously tried to make a difference. It kept me going 16 years. The worst is not being able to do what I do best because I have to fight administrators because they won't help me do what I want to do. They're the biggest problem."

"The best is being there, and taking care of residents the best way we can. Made the day brighter. The worst is too many chiefs and not enough indians. They don't know what's going on. They need to listen to what we tell them."

"The government needs to remember that these people are worthwhile. They were involved in their communities and were important people. You can't cast them aside. Why would you want to live longer if this is how it ends up?"

5.4 Detailed Facility Staff Interview Results

5.4.1 Administrator/DON Involvement in Staffing-Related Activities

The facility staff who participated in these interviews, mainly DONs, spent anywhere from 12% to over 50% of their time on staffing-related issues. The amount of time varied depending on the rate of absenteeism within the facility, the number of vacant positions to be filled, and the participation of other facility staff (e.g., an Assistant DON, a scheduler, etc.) in staffing-related activities. Scheduling and rescheduling was reported by the interviewees as taking a large percentage of time (>50%), especially if there was not a scheduler involved in the staffing process. Interviewing, screening candidates, and hiring employees were other staffing-related activities noted for taking a significant amount of time (25-50%). Advertising for vacant positions was also reported as being fairly time-consuming.

Administrators spent less time on staffing activities than DONs, dedicating 10% to 25% of their time on average to staffing-related activities. Budgeting was mentioned most often by administrators as the staffing-related task that required their involvement and demanded the most of their time.

5.4.2 Staffing Process -- the Development of Staffing Schedules

The process of developing staffing schedules varies greatly across the facilities. However, the type of

staff involved in the staffing process is fairly similar across facilities, with the DON and/or scheduler primarily responsible for the scheduling process. Some common elements that influence how the staffing process is designed and implemented include availability of facility staff, facility characteristics, and market factors. For example, some staffing processes are designed to accommodate a routinely high and anticipated absentee rate by utilizing a system that incorporates agency staff or uses "floating" facility staff (staff not assigned to a permanent unit) to fill staffing slots. Several of the facilities that belong to corporate chains utilize corporate staffing processes implemented by the DON, as opposed to more flexible processes that include input from multiple direct care staff. Market competition for labor impacts the staffing process, making it necessary to design a process that minimizes the need for agency staff and relies more heavily on facility staff through overtime, double shifts, and floaters.

Among the facilities included in the interviews, the scheduling process usually begins by developing a weekly or bi-weekly master schedule. One facility reported developing a monthly master schedule. In most cases, the master scheduling process takes into account resident census, informal measures of resident acuity, shift, and consideration for a State-mandated minimum staffing standard. Other influences on scheduling that were mentioned fairly frequently are budget restrictions and union contract regulations. One DON also considers factors such as staff preferences and who would work well together as a team. In another facility, staff help pick assignments based on seniority and those who work overtime. However, one DON stated that preferences were only considered if the staff complained enough.

Staff to resident ratio differentials are observed by shift, with all facilities in the sample maintaining the same staffing ratio for RNS/LPNs for both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shift and scheduling fewer RN/LPN staff on the 11:00 PM to 7:00 AM shift. For NAs, 45% of facilities maintain the same ratio on the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and decrease the NA staffing ratio on the 11:00 PM to 7:00 AM shift. Staffing personnel resources (usually predetermined by an annual facility budget) are typically allocated across facility units subject to these considerations. None of the facilities reported using any type of acuity-based software to allocate facility staff; however, two facilities reported using an acuity measurement package as a point of reference when determining adequate staffing levels. One administrator noted that utilizing an acuity based system to determine numbers of staff per shift or unit was not useful because staff could not be easily hired or fired to accommodate changes in resident acuity.

The staffing process is directed primarily by the DON, the ADON, or the scheduler, whose responsibilities usually include supervising the staffing process, allocating staff, or adjusting staffing. Input by other nursing staff is generally limited, and made only in terms of requesting vacation or leave. Eight out of ten facilities interviewed use a scheduler (also called the Staffing Coordinator). The Staffing Coordinator could be the DON who is ultimately responsible for the scheduling process. In about half of the facilities, the scheduler is responsible for scheduling both licensed and unlicenced staff. In the other facilities, the DON is responsible for scheduling licensed staff (RNS, LPNs) while the scheduler is

responsible for unlicenced staff (nurse aides). Oftentimes, the scheduler position is a clerical staff position located within the administrative offices, and the scheduler assists with payroll or other administrative tasks as time permits. Across the facilities, schedulers work between 16 and 40 hours per week on staffing related activities. The scheduler is usually responsible for receiving call-outs and filling vacancies as needed. To fill vacancies, facility staff are usually the first to be contacted (i.e., overtime for staff) and agency staff are used as a last resort. Facilities prefer to use per diem staff (regular staff) rather than agency staff to fill vacancies, but per diem staff usually are not available.

One interviewee described a well-defined staffing process that utilizes a scheduler. In this facility, staffing for NAs is conducted every two weeks by a scheduler housed in the administrative offices. A two-sided schedule is used, with one side showing what slots need to be filled by shift and the other side showing what slots are already filled. The scheduler highlights the unfilled slots and starts filling the holes with available facility staff and/or agency staff, if necessary. Once all the slots are filled, the scheduler prints out a daily sheet and distributes it among the nursing assistants. The scheduler also receives call-outs, filling those vacant slots with existing facility staff if available, and ultimately with agency staff.

The most unique staffing process was reported by a DON at a facility that contained nine different units (referred to as "neighborhoods"), including a 215 bed skilled unit. The facility-wide staffing budget is decentralized and staff money is allocated to each of the nine neighborhoods based on the number of residents. The staff supervisor in each neighborhood is accountable for completing a monthly master schedule, and decides on the appropriate staffing configuration (i.e., number and types of staff, including janitorial staff, for example) with input from the direct care staff in the neighborhood. The staff supervisor also has the authority to hire and fire staff in the neighborhood. Each neighborhood's monthly schedule is submitted to a central staffing office that employs 1.5 FTEs to handle staffing (in addition, these central office personnel also help with payroll and training). The central staffing office maintains a list of floating staff who are full-time facility staff that 'float' through the facility depending on the needs of any one neighborhood. The central staffing office also maintains a list of on-call, per diem staff who are used when the floating staff pool is exhausted. If on-call staff are needed to fill staffing vacancies, they are notified by the central office by mail during the development of the monthly schedule. This same scheduling process is conducted for both licensed and unlicenced staff.

Table 5.3 illustrates the development of staffing schedules for each facility included in the interviews. It denotes whether the facility uses a scheduler, how many hours per week the scheduler works, who schedules licensed and unlicenced staff, and whether or not an acuity based measure is used to determine staffing.

Table 5.3 Development of Staffing Schedules

Facility	Use a of Scheduler	Hours/Week Scheduler works	Who Schedules Licensed/ Unlicenced Staff?	Use of an Acuity Measure to Determine Staffing
1	Yes	40	DON/Scheduler	No
2	Yes	32	Scheduler	No
3	Yes	40	Scheduler	No
4	3 out of 21 facilities use a scheduler	N.A.	DON	No
5	Yes	32	Scheduler	No
6	No	-	DON	Yes
7	Yes	40+	Scheduler	No
8	Yes	40	Nurse Manager	No
9	Yes	16	DON/Scheduler	No
10	No	-	DON	No
11	Yes	20	Scheduler	No

5.4.3 Absenteeism

The majority of interviewees said that all scheduled staff reported for work as scheduled about 75% of the time (refer to Table 5.4). For these facilities, absenteeism is only a small part of their overall staffing problem. In facilities where the staff report to work as scheduled less than 50% of the time, sick calls and no-shows were listed as a big part of the overall staffing problem. Respondents attributed these problems primarily to low wages, physically demanding work, and a poor work ethic among younger workers. Many respondents did note, however, that high rates of absenteeism were associated with staff morale. However, it is difficult to determine whether low staff morale led to higher absenteeism or whether higher absenteeism led to low staff morale. One interviewee attributed the low absenteeism in her facility to an environment and culture of employee empowerment found in the facility. In this facility, staff have significant input into their schedules and CNAs can even choose the residents they'd like to work with. Interviewees from smaller facilities often reported that their staff feels obligated to ensure staffing assignments are covered.

Most facilities employ a predetermined process for last minute call-outs and no shows. Typically, facilities first try to utilize their own staff to replace the person who call-out. Positive incentives, such as

overtime or time off, are used to recruit facility staff to fill the open slots. In some instances, the nurse supervisor will ask on-duty staff to work a double shift, with overtime or vacation as incentives. In other instances, the staff scheduler will call off-duty facility staff to cover the empty position. In most facilities, agency staff are utilized as a last resort. In some facilities, however, sick calls were only replaced after staffing fell below a certain threshold. For example, in one facility, there have to be four or more calls in a 24-hour period before a replacement is called. In another facility, sick calls were not replaced at all.

Most of the facilities' attempts to stretch existing staff involved mealtime assistance; bed makers; overlapping shifts; students; volunteers; and paid companions. Those reporting the use of volunteers noted that limited hours were actually logged by volunteers, and since the hours were usually associated with activities unrelated to direct resident care, they were of little value in terms of stretching staff. The use of paid companions was reported by two facilities, but only a small number of residents out of the facility's total resident population actually used paid companions, limiting the contribution of paid companions as an overall means of stretching staff. One facility required all professional staff to be trained as nursing assistants. These professional staff assisted during mealtimes on a rotating basis, and even assisted in other aspects of resident care during staff shortages.

Methods and strategies employed by facility management to reduce absenteeism most often include a mix of positive incentives (e.g., overtime, rewards, bonuses) and negative incentives (e.g., progressive discipline or requiring an MD note for sick calls). Only half of the facility staff interviewed thought their strategies to deal with absenteeism have been effective; some respondents clearly stated that their methods were not at all successful in reducing absenteeism.

Table 5.4 When Scheduled Staff Report to Work		
Facility	Percent of time all scheduled staff report to work	To what extent do last minute sick calls and no-shows affect staffing in your facility?
1	50%	Big problem
2	>75%	Part of the problem
3	<25%	Big problem
4	>75%	Part of the problem
5	>75%	Small problem
6	51-75%	Part of the problem
7	>75%	Part of the problem
8	>75%	No problem
9	>75%	Part of the problem
10	26-50%	Small problem
11	<25%	Big problem

5.4.4 Recruitment and Retention of Facility Staff--Extent of the Problem

About half of the interviewees reported that recruitment and/or retention of facility staff is a "large" part of their staffing problem. The other half of the interviewees reported that it is "some" of the problem in terms of their staffing shortage. Facilities use an assortment of strategies to improve recruitment and retention, including: hiring bonuses, recruitment bonuses, rewards for long-term employment, generous benefits, NA training, cooperative programs with vocational/nursing schools, career ladders, special pay rates, and job fairs. One facility took a pro-active stance, initiating a task force to address the problem. One DON talked about the facility's efforts to reach out to the neighborhood community with social services (such as offering adult computer classes). This facility was trying to build an image as a caring employer and show potential employees within the community that it is a good place to work, which turned out to be more effective than traditional advertising (such as a newspaper campaign).

Most interviewees evaluated their strategies to address recruitment and retention as somewhat effective. However, the lack of an available labor pool, low wages, and physically demanding work were consistently cited as reasons for staff shortages.

5.4.5 Ideal versus Actual Staffing Levels

Interviewees were asked what an "ideal" staff-to-resident ratio would be, given no budgetary or labor constraints. Table 5.5 reports these ratios. Most respondents made no distinction between RNS and the LPNs when calculating their ideal staffing ratio, and a few interviewees combined these two staff types. In general, ideal RN/LPN staffing ratios for the first and second shifts (i.e., usually 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM) ranged from 1:12 to 1:25, with one DON reporting a 1:29 ideal ratio. The ideal RN/LPN ratio for the third shift (usually 11:00 PM to 7:00 AM) was extremely variable, ranging from 1:15 to 1:50. Ideal NA ratios ranged from 1:5 to 1:12 on the first and second shifts, and from 1:10 to 1:17 on the third shift.

The facilities' actual staff to resident ratios were either at or below the respondents' ideal ratios. Actual RN/LPN staffing ratios for the first and second shift fell between 1:15 and 1:36. Actual RN/LPN staffing ratios for the third shift ranged from 1:20 to 1:60. Actual aide ratios ranged from 1:6 to 1:16 on first and second shifts, and from 1:10 to 1:25 on third shift. While many of the facilities listed current ratios that were not extremely different from their ideals, one facility had an actual LPN ratio of 1:30 for the first and second shifts and 1:50 at night, with an ideal ratio of 1:15 for all three shifts.

Factors that prevented the facilities from actually achieving their "ideal" staffing level included availability of labor, area market competition (both health and non-health related), low wages, high turnover, reputation of the facility, and geographic location of the facility. One facility had difficulty finding and keeping staff because they only offered 12 hour shifts.

Table 5.5. Adequacy of Current Staffing Levels (ratios for skilled care)

Facility	Shift	Ideal Staff to Resident Ratio RN	LPN	AIDE	Current Staff to Resident Ratio RN	LPN	AIDE
1	7-3	RN/LPN 1:25		1:12	N.A.	N.A.	N.A.
	3-11	RN/LPN 1:25		1:12	N.A.	N.A.	N.A.
	11-7	RN/LPN 1:50		1:12	N.A.	N.A.	N.A.
2	7-3	RN/LPN 1:20		1:9	RN/LPN 1:20		1:8
	3-11	RN/LPN 1:20		1:9	RN/LPN 1:20		1:8
	11-7	RN/LPN 1:50		1:15		N.A.	N.A.
3	7-3	1:20	1:20	1:8	RN/LPN 1:25		1:10
	3-11	1:20	1:20	1:9	RN/LPN 1:25		1:16
	11-7	1:30	1:30	1:15	RN/LPN 1:25		1:25
4	7-3	RN/LPN 1:20		1:6	RN/LPN 1:30		1:8
	3-11	RN/LPN 1:20		1:8	RN/LPN 1:30		1:10
	11-7	RN/LPN 1:30		1:15	RN/LPN 1:60		1:15
5	7-3	RN/LPN 1:18		1:5	RN/LPN 1:36		1:6
	3-11	RN/LPN 1:18		1:8	RN/LPN 1:36		1:9
	11-7	RN/LPN 1:36		1:15	RN/LPN 1:36		1:16
6	7-3	1 super	1:15	1:7	RN/LPN 1:15		1:7
	3-11	1 super	1:15	1:9	RN/LPN 1:15		1:9
	11-7	1 super	1:20	1:10	RN/LPN 1:20		1:10
7	7-3	RN/LPN 1:12		1:6	RN/LPN 1:20		1:8
	3-11	RN/LPN 1:12		1:6	RN/LPN 1:20		1:10
	11-7	RN/LPN 1:24		1:15	RN/LPN 1:40		1:20
8	7-3	RN/LPN 1:21		1:8	N.A.	N.A.	N.A.
	3-11	RN/LPN 1:21		1:8	N.A.	N.A.	N.A.
	11-7	RN/LPN 1:21		1:17	N.A.	N.A.	N.A.
9	7-3	1/unit	1:15	1:10	1/unit	1:30	1:10
	3-11	1/unit	1:15	1:10	1/unit	1:30	1:10
	11-7	1/unit	1:15	1:10	1/unit	1:50	1:15
10	7-3	1/floor	1:25	1:6	1:25	1:14	1:11
	3-11	1/floor	1:25	1:10	1:100	1:25	1:14
	11-7	1/floor	1:50	1:15	1:100	1:50	1:20
11	7-3	2 supers	1:29	1:6	2 supers	1:29	1:11
	3-11	1 super	1:29	1:11	1 super	1:29	1:11
	11-7	1 super	1:38	1:12	1 super	1:38	1:15

5.4.6 Government Mandated Minimums

The final question for the facility staff interviews centered on whether the Federal government should mandate minimum staffing requirements. Partly due to the difficulty facilities are currently experiencing in finding adequate numbers of qualified staff, some of the interviewees do not want the Federal government to mandate a minimum staffing level. One DON said that a Federal standard would create more problems than it would solve because the staffing issue is not one of money, but one of available labor. Under a mandated minimum, this DON thought that the nurse aide positions could get filled by uncaring, unqualified people in order to staff up to the standard, possibly leading to an increase in resident abuse. Another respondent said it would be financially impossible to staff at the level proposed by NCCNHR, even with only 50% Medicaid residents (which is atypical for most nursing facilities), because the competition within the labor pool would cause salaries and then costs to skyrocket. Other interviewees focused on the issues of State requirements already in place and the facility's ability to decide how Federal resources should be utilized. One DON felt there was no need for Federal staffing levels because the state requirements for 'decent' and 'adequate' staffing levels are satisfactory. Another interviewee pointed out that a minimum standard does not necessarily lead to quality care, and the Federal government should leave the allocation of funds up to the facility.

The majority of respondents, however, noted that there should be a Federally mandated staffing level. For example, several respondents thought that their State requirements were not adequate for the needs of the residents, and that the Federal government should mandate levels higher than the State's. One interviewee thought that facilities might be more likely to pay attention to Federal requirements than State requirements. Others thought that the government should create a minimum standard to ensure quality care for residents. One respondent noted that the Federal standards should be sure to account for regional variations in the labor pool. Several interviewees noted that the government also needs to appropriate the funds or include an associated budget mandate for increased staffing standards in order for the mandated levels to be feasible. One respondent thought that HCFA has to be realistic about resident needs when creating these standards and allow flexibility in staffing to account for these needs. For example, she noted that the RUGs system does not capture how much time is takes to care for residents with behavioral problems, and that it would be difficult to measure a staffing level of effort for a 'typical' behavioral resident.

5.5 Conclusion

The nurse aide focus groups and the facility staff interviews were intended to provide some qualitative information about the current staffing situation in nursing homes that could be used in conjunction with the quantitative staffing and outcomes analysis. It was the goal of these activities to obtain information from direct care workers (through the nurse aide focus groups) and from the facility staff who schedule and oversee the direct care workers (through the facility staff interviews). The general topics covered through the focus groups and interviews centered on how staffing is conducted, the extent of

absenteeism in nursing facilities and how this impacts direct care workers and residents, and how facilities deal with absenteeism.

Both the focus group and interview participants noted that the current staffing situation in most facilities is due to a shortage of available nurse aide workers in the labor market. Many facilities reported vacant NA positions due not only to a high turnover rate among NAs, but a generally low unemployment and a shortage of applicants for NA positions. NAs noted that they often worked short staffed because facilities are short staffed to begin with (i.e., vacant positions are not filled); the short staffing problem is compounded even further by a high rate of absenteeism in many facilities. Facility staff employ a variety of positive and negative incentives to reduce absenteeism, and while NAs noted the need for negative incentives in some cases, many cited positive incentives (in the form of employee appreciation, bonuses, etc.) as the best method to reduce absenteeism.

Facility staff readily acknowledged that the NA job is a difficult one; it is physically demanding, wages are low, and NAs often don't feel a sense of accomplishment because the typical nursing home resident is declining in health status, rather than improving. While NAs tended to agree that the work was physically demanding and the wages were low, they cited a lack of respect from the licensed staff as having the biggest effect on their sense of accomplishment.

Most facility staff reported that they take case mix into account when determining what the appropriate staffing configuration should be, although the measures of acuity used in making these decisions were very informal and subjective in nature. NAs, however, don't believe that case mix is taken into consideration when scheduling staff.[3] In addition, they reported not being involved in schedule determinations (such as the appropriate number of staff or assignment of particular staff to particular units) even though they provide at least 80% of direct resident care and feel they know the resident's status and needs better than the licensed staff.

One interesting contrast between the NA focus groups and the facility staff interviews was related to absenteeism, more specifically to how staff calling out sick is handled. Most facility staff who participated in the interviews reported a process for receiving sick call outs and filling those vacancies,

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[3] There is some independent evidence that bears on this issue and it would appear to support the NAs contention that case mix is not typically taken into consideration when scheduling staff. Table B.1 in the appendix to Chapter 3 indicates that the 1998 mean hours per resident day (standard deviation) in U.S. nursing homes for RNs, LPNs, and Aides were 0.53 (0.73), 0.72 (0.54) and 2.01 (0.75), respectively. The mean hours and standard deviations for the previous year were nearly identical. To the degree that case mix differs among facilities and to the degree that facilities staff according to case mix, the investigators would expect the standard deviation of the mean hours per resident day to increase. A standard measure for comparing the variability of different means is the coefficient of variability which is obtained by dividing the standard deviation by the mean. The coefficient of variability for RNs, LPNs, and Aides are 1.35, .75, and .37, respectively. In other words, there appears to be very little variation in nurse aide staffing among facilities of widely different case mix in contrast to LPNs and particularly RNs.

including offering permanent staff overtime or utilizing per diem staff and agency staff. However, the majority of NAs reported that their facilities often do not even attempt to replace vacancies caused by staff calling out sick unless a certain threshold of call outs has been reached.

Both the focus groups and the facility staff interviews point to the shortage of available staff to fill vacant NA positions as one of the key determinants in the current staffing situation in many facilities. However, the shortage of staff is further exacerbated by high absenteeism. And as NAs continue to be frustrated and overburdened by short staffing, absenteeism will continue to be high, creating a cycle of short staffing that will be difficult to break.